SOMA WEISS

Soma Weiss

Dr. Soma Weiss has been promoted from associate professor to professor of medicine at the Harvard Medical School and also appointed physician-in-chief to the Peter Bent Brigham Hospital, Boston, to succeed Dr. Henry A. Christian, who will retire next September.

Dr. Weiss was born in Bestercze, Hungary, on January 27, 1899. Between 1917 and 1920 he served as demonstrator in the Institute of Physiology and demonstrator and research fellow in the Institute of Biochemistry of the Royal Hungarian University, Budapest. There he was particularly influenced by Professor Eotvos and Professor Hari, respectively professors of physics and biochemistry. He received the degree of A.B. from Columbia University in 1921, and the degree of M.D. from Cornell University in 1923. He was closely attached to the late Professor Hatcher, professor of pharmacology at Cornell. From 1923 to 1925 he interned at the Bellevue Hospital, New York City on the service of Dr. Eugene DuBois. He came to the Thorndike Memorial Laboratory, Boston City Hospital under Dr. Francis Peabody in 1925, and held various positions there, finally becoming assistant director under Dr. George R. Minot. In the Department of Medicine of the Harvard Medical School he was assistant in 1926, instructor in 1927, faculty instructor in 1928, assistant professor in 1929, associate professor in 1932.

During his career as student, teacher and administrator he has engaged actively in original research and has contributed continuously to medical literature. His papers (in all, one hundred and forty-six) cover wide fields in pharmacology, biochemistry, neurology and internal medicine. His first contribution was to the German literature when he was 19 years of age: "The Significance of the Increased Respiratory Quotient in Forced Breathing and Increased Muscle Work." His early papers contain studies on digitalis, strychnine, physostigmine, quinine and other drugs, and on the mechanism of vomiting. In 1926 appeared the first of a series of important papers on the velocity of blood flow in normal and disease conditions, written in collaboration with Dr. Herrman L. Blumgart. There also appeared papers on hypertension, rheumatic heart disease, subacute bacterial endocarditis, dissecting aneurysm, nephritis and an unusual contribution which has been abundantly confirmed, entitled: "Hemorrhage from Lacerations of the Cardiac Orifice of the Stomach Due to Vomiting," written with Dr. G. Kenneth Mallory. In 1933 a very important paper was published in Medicine by Dr. Weiss and Dr. J. P. Baker: "The Carotid Sinus Reflex in Health and Disease: Its Role in the Causation of Fainting and Convulsions." Since 1933 there have appeared a number of timely and therapeutically practical articles on the relation of viatmin B_1, to cardiovascular disturbance.

This account would not be complete without at least mentioning the large number of young physicians who have trained under Dr. Weiss's immediate supervision at the Thorndike Laboratory, many of whom are occupying important teaching and research posts in various parts of the world. His good practical judgment is being sought by many medical students and young doctors who come to him for advice. On ward rounds he has shown a rare combination of efficiency, uncanny diagnostic skill, excellent memory, ability to listen as well as to teach, and devotion to the welfare of the patient. It seems important to set down here (in case it disappears forever in his new august surroundings) a foible of Dr. Weiss which has delighted his students and colleagues. Although he is an apt linguist in many re-

spects, his ability to pronounce the English V in such words as *involves* and *vomit* is fascinating. It should also be mentioned that it is the despair of the City Hospital pathologists to find a larger liver (or is it heart or spleen?) than Dr. Weiss has seen. There is a mystery about this because one of the instructors at Cornell who had Soma Weiss as a student has stated that even then he had seen a larger liver (or heart or spleen?) than anyone else. Because of many friendly memories as well as because they are losing a physician of great talent, members of the staff throughout the Boston City Hospital are regretting exceedingly the approaching departure of Dr. Weiss. But, they must be feeling a certain sense of pride that they are sending to the Peter Bent Brigham Hospital a man who is considered to be of stature sufficient to occupy the position so long honored by Dr. Henry A. Christian.

Frightened People

Elton Mayo, Professor of Industrial Research, Harvard University.

I shall begin by limiting my topic in two directions. I have no intention, for example, of quoting cases of a psychiatric type. I hope that such instances as I cite will be nearer the facts. This somewhat ambiguous phrase must not be taken to imply any aspersion upon a modern and most valuable development in medicine. I owe too much to psychiatry and psychiatrists to be guilty of such ingratitude. My meaning is merely that when I cite a case, I hope that it will be immediately possible for every member of the audience instantly to translate it into terms of his own experience—into terms of a similar situation with which he is directly acquainted.

The other limitation is that no question of the organic or mental origin of a disorder will be raised—as if these were alternate possibilities. I have no thesis, overt or implied, that the origin of any ill is "all mental". On the contrary, I assume in every instance an organic disability of some kind—unbalance, infection, defect, pathology: but I assume also the existence of other factors of varying importance. These two limitations make it evident that I am confining my attention to the simple and the obvious. My comfort in this admission must be that the simple and the obvious are perhaps not often enough or not clearly enough stated.

A patient is a case—a case of something that can be looked up in a medical dictionary (B for botulism, T for typhoid); he is also a human being. Both aspects are important to the physician. In the medical schools of thirty or forty years ago the most elaborate care and attention were given to study of the former, the ailment, in clinic, hospital, and laboratory; no attempt was made to develop any systematic study of the human being. I shall later claim that this neglect was not altogether unjustifiable in the social circumstance of that time. But for the moment I wish merely to point out that the neglect carried curious consequences for the practice of medicine. For example, it was very generally believed in those days that the student who did best in his studies was very rarely the man who did best in professional practice afterwards. I am not interested in the truth or falsity of this belief; its interest here is merely as evidence that in some inarticulate way the physicians of that time were already aware of an omission in their general training.

Now when a patient walks into a consulting room he requires two kinds of aid from the physician. The first is medical

attention, the second is assurance: in the ordinary consultation the second is as important as the first. The need of assurance is not adequately met by a hearty manner —nor by dogmatism or breezy self-confidence. The world is less suggestible than it used to be, and more obsessive. Especially in these days of universal education the assurance offered must be discriminating; it must be pointed at a particular item in the particular mental context—an item that has been discovered to be there. This differs in different patients, and is almost always left to the physician to discover. By this I mean that the physician is never told directly what the need is; sometimes, usually indeed, the patient cannot tell him, sometimes he does not want to. But in very many instances the physician's success will depend upon discovery of the exact locus of the need for assurance. The physician must therefore make two diagnoses: one of the organic ill, the other of the need of assurance. The latter is often simple, rather easily discovered. But it is unwise to ignore it because it is simple.

Almost twenty-five years ago in Queensland a young doctor came to me at the University and made a statement to the effect that his patients always suffered a "functional complication"—in the phrase of that time—of an organic ill. His practice, which was large, was in a good residential district and the average case was not very serious. He claimed that in the majority of these instances it was not difficult to mitigate, or to get rid of, the organic condition. "And then I find," he added, "that the patient is no better. I have done nothing to get rid of the functional complication." This young man had taken a very good degree at a famous British university; he was very keenly interested in his work. In addition to this he was a high-minded and sympathetic human being. He had always attempted to make an approach to the person in a consultation. The method he had adopted was to assume in the patient an interest equal to and like his own. He would draw diagrams, take down a textbook, explain the nature of the disorder. And this method had no success at all. His patients had no desire to become amateurs of science or medicine; each one wanted reassurance as a person. The more the doctor enlarged upon "the case", the more the patient felt it as annihilation of the person. The physician was defeating his own admirable intention.

After some discussion he realized his error and determined to change his method. From this time on, he attempted to discover the fear and to reassure. The sequel was interesting: in a few months his practice had greatly increased; in a few years he had given up general medicine and become a specialist.

A person in need of assurance is a frightened person; but it is evident that the nature and degree of the fear will differ in different people. If the assurance is to be of the right kind and addressed to the appropriate locus in every individual instance, then the physician is in need of an approximate classification that will help him to identify, and be sufficiently adequate to, the situation set before him. With this in mind, and for purposes of ordered discussion, I have devised a classification of three types of personal situations. The classification is arbitrary and empirical; it is based upon an approximate estimate of the kind of fear and its distribution in the individual's thinking. In the simpler cases there is not much fear and what there is tends to attach itself to the actual organic disorder. In the more difficult cases there is a great deal of what has been termed "free anxiety", distributed widely through almost all the patient's thinking. In such a situation as this latter there is not necessarily any immediate or obvious relation between the organic dysfunction and the fear.

I. The first type of case may be described as illness under conditions such that the necessary assurance is almost automatic in the situation. In three continents I have happened across country districts in which the local physician was a first-class medical

man practising there because he liked the life of the countryside and disliked cities or crowded industrial centres. The chief local occupation was farming of various types, the social interrelation of the various family groups was complex and strong. Add to this an immense, and justified, confidence in the competence of the physician and my picture is complete. Even in these days of crowded city life one can discover a few instances of somewhat similar situations. For instance, if a child falls ill of mumps or measles in a well-ordered house in a well-ordered residential district; if a member of an athletic team is injured and is instantly cared for by the team's physician; or a soldier in wartime.

In instances such as these the need of assurance is in the charge of a closely united social group. The physician is an active member of the group and must know how to identify himself with the social reassurance function as he proceeds to technical examination. But everything in the surrounding is saying to the patient, "Here is the doctor. *Now* you will be all right." Since the patient usually knows the doctor personally and has known him for years, he is also saying this to himself. There is what one might call a total conspiracy of reassurance. Everyone takes the ailment as obvious; no one is frightened. This is almost a social ritual, and is automatic.

II. This almost automatic social assurance was at one time more general than it is now; it may indeed have been universal in the earlier stages of our history. Here may perhaps be found the historic justification of that seeming neglect of medical schools to study the human being as well as the ailment—the neglect of which I spoke earlier. But the physician of these days can no longer assume social collaboration of this extensive and adequate type in his ordinary consultations. The second type of case I specify must therefore be regarded as representing the usual or average medical consultation of today. The patient knows little or nothing of the doctor; he has been "sent" by someone, friend or physician. And the physician knows little or nothing of the patient—his family, his daily work, his social affilations. In this situation the second diagnosis, the localization of the need of assurance, suddenly becomes more important. Little or no assistance, explicit or implied, can be expected from the patient's immediate and social background. The instances I cite under this general heading develop from the simple to the less simple.

(a) The most simple instance is that in which the assurance needed relates itself directly to the ailment or to a symptom. A patient with abdominal pain, for example, has given much thinking to identification of the pain with gastric ulcer or malignancy. Success in treating the organic disorder depends in part on discovering what the patient is frightened of as a result of "overthinking". An eminent physician, now in retirement, tells of himself that in later middle age while still active he noticed that he was becoming breathless after mounting stairs. He reflected uneasily that he should perhaps consult a specialist colleague. Then one day as he came out of the subway he noticed that he was more breathless than usual. Suddenly he remembered that he had ascended on the escalator and had not mounted steps at all. He laughed and lost both the fear and the symptom. The physician being a skilled person could thus reassure himself or, rather, could be directly reassured by the obvious absurdity of the situation. The average patient without technical knowledge requires skilled assistance, and assurance, before he can develop such a point of view.

(b) The next instance cited is a situation in which the assurance demanded may have no direct relevance to the ailment protested. The assurance demanded is nevertheless particular and not necessarily evidence of a general anxiety. An industrial nurse, whose mornings were occupied in the conduct of a small clinic in a factory, made some interesting observations of this type of case. After two years of

work in the factory, she came to know a considerable number of workers rather intimately. Being a good interviewer and observer, she noticed that it was rarely the minor casualty, for example, a cut or splinter, that brought a worker to her. Frequently, the worker would dress such an injury himself in a rough manner and without leaving his job. On the mornings that he brought such an injury to her for attention, there was some other matter he wished to discuss. And it was always a problem with respect to which he needed assurance. It might be medical—his own health or that or some member of his family—or it might be social—a son, daughter, or wife. The nurse became very alert to, or it might be said expectant of, the second consultation. A patient may bring a minor ill to a physician when he really wishes to consult him on another problem. This is the more characteristic the better he knows his physician.

(c) The reassurance must be addressed to the appropriate person who is not always the patient himself. A girl does very well in her studies at college but does not find herself at ease with her associates. She does not go to dances as they do; she does not know any young men. She is apt to feel the social disability most acutely during the general chatter at mealtime; she develops globus hystericus. This does not trouble her greatly until she returns home for the holidays. Her father—sensitive, intelligent, educated—becomes alarmed and takes her to a throat specialist. The specialist sees the girl alone and speedily loses interest; he pushes her off with a vague assurance that she will be all right. He does not see the father except to say farewell. The father, still dissatisfied, goes to his physician. The latter realizing that assurance is needed explains the condition at length and the father finally is comforted. When the father is reassured the daughter's symptom begins to abate.

Two comments suggest themselves. The first is obvious, namely, that in such a case effective assurance is the most important part of the treatment. Further, the assurance must not be addressed to the patient only but to any person in her immediate social context whose affection and alarm provoke a consequent increase of alarm in her.

The second comment is an observation on the effect of diminished social contacts upon family life. In a small and ordered society the closely organized family operates, like the social group itself, to support the doctor and reassure the patient. In a situation where social contacts are weakened or diminished the highly organized family operates in a contrary manner. Its isolation reinforces its anxiety; it tends therefore to alarm and to exaggeration of the ill rather than to reassurance.

III. The third type of case includes the really frightened people, those people who suffer a general alarm about themselves, their health, their position in the world. In such cases the ailment may itself be organic only in a minor fashion: it may in a sense be provoked, and it will surely be exaggerated, by the terror and general need of assurance. These cases are the exact contrary of the first type: in the first type the social system conspires to reassure, in this third type the lack of assured functional relation to the social system is conspiring to produce a sense of insecurity and terror.

(a) The simplest cases are instances of what Durkheim has called *anomie.* A woman of seventy enters the outpatient department of a hospital complaining of pain in her legs. The hospital records show that she has periodically entered herself with this complaint over a number of years. The medical examiners have tended to refer her to the psychiatrists and the psychiatrists to send her back to the medical clinic. Encouraged to talk, she explained that for most of her life she had been a working housekeeper in hotels and successful in that function. Having saved money, she determined to "retire" when the economic depression diminished the amount of such work required. She acquired a room and furnished it; she devel-

oped a routine of living. The effect of this newly acquired routine of living was to shut her off from all active or effective human contacts. If she talked to women they "talked only of their troubles"; there was no other person with whom she could talk. It was after some months of this isolation that she presented herself at the hospital. For a person who has been continually active, who is still amazingly serene in the circumstances, this functionless style of living constitutes a major dysfunction. While this aspect of her situation was being made clear, she dropped all reference to and apparently forgot the pain in her legs. The hospital attempted to develop new and satisfactory human relationships for her.

This case relates itself to the experiences, quoted above, of the industrial nurse. It is a more complicated development of the same type of situation. The individual is unable herself to make articulate the nature of the dysfunction; but she is aware of an exaggeration of the organic condition, and her limited capacity for thought and expression lights upon this, the organic condition, for complaint to the physician. The physician naturally is unable to confirm this expression.

(b) A chance phrase dropped inadvertently by a physician may seem in such cases actually to provoke a disorder. This is not suggestion or suggestibility; there is no imitation of the appropriate organic symptoms as in hysteria. In one of the three well-ordered country districts of which I spoke above, the authorities decided to institute a high school. The newly appointed headmaster came from a large city and, some six months after his arrival, he presented himself in the physician's consulting rooms and asked for a medical examination. A short conversation showed that he was not a candidate for life insurance, that he had suffered no accident, that he complained of no particular symptoms. The physician found himself somewhat puzzled by a consultation quite outside the ordinary run of his practice: however, he proceeded to subject his patient to an extremely careful examination. He found nothing that could be reported as variant from what might be expected in a normal person of the patient's age, other than a certain suggestion of apprehension. As the patient left him, he said more by way of conversation than diagnosis, "Your heart's a bit sluggish; don't get influenza." The patient left him and a week or so later—in 1918—the alarm of "Spanish Influenza" began. The patient lapsed into a condition of extreme anxiety and had to be sent to the city for medical care.

In this instance study of the individual showed that he had never in any real or human sense "belonged" to a group of people. It was this, rather than any mere city-bred character, which made him so utterly foreign to the country district. A solitary boyhood with few companions had been followed by an adolescence in which he had worked desperately for distinction in the educational system and had in some measure succeeded. Then an unfortunate incident—while staying in the house of an acquaintance he had seduced a maidservant and had felt it his duty to marry her. His wife was a pleasant, uneducated creature, utterly unfitted to be the comrade of an educator. This fact still further separated him from his fellows and he became a prey to a heavy conviction of sin and to forebodings of calamity. His foreboding took the form of hypochondriacal alarms about his health. It was these alarms, and his general feeling that he was a social outcast, that took him into the consulting rooms of the physician.

Instances such as this may be multiplied almost indefinitely in any modern industrial or business centre. They may seem to approximate or to shade into those cases that demand the special care and attention of the psychiatrist. Nevertheless it must be said that it is not intelligent or sensible for medicine to seek to unload all the personal problems it encounters upon the already overburdened shoulders of the psy-

chiatrist. Furthermore, while many of these cases do not benefit greatly by prolonged "analysis", it is invariably necessary that something should be done to alter and amend effectively their social situation.

At this point I must pause to call attention to an interesting development in the theme of this address. I began by observing that a patient requires of his physician not only medical diagnosis but also personal assurance. I attempted to devise an arbitrary and empirical classification of three types of personal situation—the classification based upon an approximate estimate of the kind of fear an individual suffers and its distribution in his thinking. It is now apparent that observation of the type and extent of assurance needed has become observation also of the kind of social situation in which the patient habitually finds himself, the kind of social conditioning that has produced him. The individual who lives in a small and ordered community requires small assurance; the whole social situation, of which the physician is an essential part, conspires to reassure him. In a larger society an individual assured of his place and function may as a patient require assurance. But in this instance the assurance is probably more or less particular, more or less easily discovered—it is something left over, as it were, by the social order. At the extreme end of the scale is the individual who gets no assurance from his surrounding: on the contrary, his lack of continuous and intimate relationship with others inspires in him a fund of free anxiety which attaches itself to all he thinks. In brief, one may claim that the need of assurance is an index not only of personal but of social well-being. The large-scale modern society very easily develops patches of social disintegration, of diminished human association. Within such patches is found great human unhappiness which cannot be explained by the usual economic, psychological, or political studies.

This observation has importance not only for medical practice, but for every human activity. The administrator in business or industry is already aware of increasing difficulty in the task of securing continuous and wholehearted coöperation from large associations of people. Diminished faith in the society shows itself in industry as disquiet, unrest, disorder. Diminished social order—frightened people.

In these days it is characteristic that the small, well-ordered society is becoming less common, the large industrial and populous centres more common. Especially in these days then the physician in his ordinary practice must address himself to two diagnoses—the one a diagnosis of the medical ill in the strict sense, the other a diagnosis of the need of assurance. This latter involves careful investigation of the present situation of the individual, and of his personal and social history. It is no doubt possible sometimes to mitigate or banish an organic ill without the second diagnosis: but it is not possible so to *cure* the patient. The patient is not fully cured until he is himself certain of his restoration to health. Confidence in his medical attendant is established when the relevant personal situation has been brought to light. This is evidenced by a sudden disposition in the patient to "unload" everything upon the doctor. The capacity for assurance that a physician develops in such a context is astonishing—unnecessary pains and other symptoms will disappear almost at a word.

The physician who follows such a method has the satisfaction of knowing that he has been of immense aid to a fellow human being. I hope I have made it clear that he has the further satisfaction of knowing that he has contributed some small item of knowledge to the difficult problems—personal, social, political—of our difficult age.

Editor's Note: An address given Jan. 18, 1928 at the Harvard Medical School.

DR. CHARLES MORTON SMITH, 1867-1938

Dr. Smith was born on the 20th day of October, 1867 in Dublin, N. H. He was educated in the local schools and in 1889 he entered Harvard Medical School, but did not graduate until 1894 because of completing an internship at the Boston City Hospital before graduation; there he came under the influence of Dr. J. S. Howe, then professor of Dermatology at Tufts College Medical School, and Chief of the Department at the Boston City Hospital.

In 1894 he was appointed assistant physician to the Department of Dermatology at the Boston Dispensary under Dr. Abner Post, where he remained until 1914. From 1900 to 1905 he was also an assistant in the Department of Dermatology at the Boston City Hospital. Besides his close association with Dr. Howe and Dr. Post in those two hospitals, he also assisted them in their offices. Both these men were exceptionally keen observers and clear thinkers in dermatology and syphilis.

In 1914 he was called to form and head a new syphilis department at the Massachusetts General Hospital, with Dr. Abner Post as consultant. As usual he gave all that was in him, spending practically every morning, six days a week through at least ten months of the year. Here he taught the Harvard Medical students and for a number of years the Harvard Dental students; and during the war, by arrangement with the Surgeon General's office he gave for a number of months, intensive instruction to small groups of officers in clinical dermatology and syphilology.

His teaching activities started as early as 1896 when he was assistant in syphilis at the Harvard Medical School and he continued through various grades to clinical professor of syphilology, in 1921. With this rank he taught until 1926 and remained clinical professor emeritus from 1926 to his death.

He has the distinction of having been at one time head of the only teaching department in this country limited to syphilis. He was one of the founders and later president of the New England Dermatological Society and of the Atlantic Dermatological Conference in the same year. He was president of the American Dermatological Association in 1930 and was chairman of the section of Dermatology and Syphilology of the Massachusetts Medical Society in 1936.

Dr. Smith did not make many contributions to medical literature, but those which he did were of exceptional quality, especially his "One Thousand Cases of Congenital Syphilis," which was really a remarkable contribution. Always modest, often to a fault, he resisted all efforts to try to induce him to write a book, yet with his keen understanding of the patient, as well as the scientific details of the patient's ailments and his very exceptional kindliness, it seems most regretable that he never did. His reputation in syphilis was international. Though he modestly disclaimed being an expert in dermatology, yet his diagnostic skill in this field was almost uncanny. His ability to see everyone's point of view made him an exceptional physician, scientifically skilful, yet primarily the patient's friend. These two qualities made him a particularly useful consultant. He was an exceptional teacher, first because of his knowledge, then because of his ability to impart it simply and clearly, and because he always taught the student never to forget the patient and the emotional troubles the patient was having because of his disease.

His training and clinical experience lasted for many years before modern laboratory technique was thought of, at a time when a diagnosis had to be made by a combination of what one could see, hear, feel and one's wits. Quick to adopt anything new in modern syphilology he never allowed mere laboratory methods to dull his acuity of observation or judgment.

AUSTIN W. CHEEVER, '14.

BOOK REVIEW

Socialized Medicine in the Soviet Union. By Henry E. Sigerist, M.D. New York: W. W. Norton and Co., 1937. 378 pps.

The title of Dr. Sigerist's book gives only a partial clue to the nature of its contents. The American reader who expects to find a detailed description of the practice of what is ordinarily called "curative medicine" will probably be disappointed.

The author is interested rather in drawing a picture of medicine in a far broader sense, and in relating it to the whole of Russian civilization under the Soviet regime. To this end, he spends a great deal of time in discussing such topics as the philosophy of Marxism, the history of Russia prior to the revolution, and the administrative structure of the Soviet Union. Other chapters are concerned with measures directly or indirectly affecting health, such as those dealing with working conditions, rest and recreation, food, housing, maternal and child hygiene, and the control of social diseases—under which are included not only venereal diseases but also tuberculosis, prostitution, alcoholism and crime. Finally, there are descriptions of the training of physicians, the facilities for medical research, the control of epidemics, and the methods by which medical care, in the ordinary American usage of the term, is made available to the people. Scattered throughout the book are informative discussions of topics which have bulked large in the foreign press, notably abortions and divorces.

The information which is presented will be interesting and novel to many an American reader. He will learn, for example, that in 1934 three-quarters of all Russian medical students were women, that physicians, along with engineers, have ranked since 1935 among the most highly paid groups in the population, and that physicians, particularly those in the rural regions, are invited to take post-graduate courses at frequent intervals, with all their expenses paid and their salaries continued. He also will learn quickly that Sigerist is an enthusiast for all things Soviet, and especially so when the present or future of Soviet medicine is in question.

Confronted with such an array of topics —and the list given above is by no means exhaustive—the reviewer may well be pardoned if he confines his remarks to a few general impressions and issues suggested by Sigerist's book, and refers the reader in search of more specific information to the book itself.

Perhaps the most striking point brought home by this and other works on Soviet medicine is the magnitude of the change in the facilities available for providing medical services. We may select a few figures at random. In 1913, there were less than 20,000 physicians in all of Russia; by 1936, the number had increased to approximately 90,000. Hospital beds increased from 176,000 in 1913 to 443,000 in 1933, with substantial further additions promised by 1937. In 1914, there were 4 tuberculosis dispensaries; in 1936, there were 500. Many other examples of the same sort could easily be cited, but they would merely confirm the general picture. With all due allowance for statistical optimism, the record is an imposing one.

Sigerist is not blind to the defects and inadequacies that still exist, nor apparently are the Russians themselves. Many of the physicians are poorly trained or incompetent. Many of the hospitals are antiquated or badly managed. Rural medical service leaves much to be desired. Morbidity rates for certain diseases remain at a higher level than in other countries. "But these shortcomings are seen and admitted freely . . . Shortcomings will be remedied sooner or later." Whether or not we can look at the matter thus philosophically, it remains true that great progress has already been made, with relatively little upon which to build at the outset.

A careful review of the undoubted achievements in Soviet Russia raises squarely a number of issues which must be

considered in other countries as well. First of all, not only medicine but everything else is "socialized" in Russia. Is it possible, then, to have an effective socialization of medicine in an economy which is primarily capitalistic or individualistic in structure? Sigerist nowhere expresses his own opinion clearly and definitely on this point. It is perhaps not unfair to conclude, however, that his answer to the question would be largely in the negative. Otherwise he would hardly have spent so much time in describing the background and structure of Soviet Russia and its general economy.

Does the effective socialization of medicine (not merely health insurance, but state physicians on salary, and hospitals and other facilities owned and operated by the state) hinge upon the socialization of the rest of the economy? One is tempted to reply that in every country there is at least some socialization of medicine, and that some of this, at least, is not ineffective. One is tempted to answer further that the socialization of another professional service, education, has gone to considerable lengths in all important countries, and that while there are many critics, there are few who would advocate the abolition of our public schools. To some extent, then, the question is academic. Some socialization of medicine and a considerable amount of socialization of education have come about in economies which show few signs of becoming completely socialistic in the near future.

Such an answer, however, would be far from complete. It is just as this point that Sigerist—and perhaps Soviet Russia as well—makes what are probably his most significant contributions. For "medicine," as defined by him, is far more than a matter of bottles or special diets, or skillful surgery, or even inoculations against smallpox or diptheria. "Medicine" includes all those factors in a civilization which looks toward the preservation or restoration of health; hence the emphasis which he lays upon such conditions as hours of work, recreation, and housing.

Translated into these terms, the question not only becomes more difficult to answer, but raises other questions of perhaps equal importance. Are we in this country inclined to attach too much weight to the more dramatic procedures and critical conditions, and too little to the underlying factors which bring about these conditions and make these procedures necessary? Assuming that some balancing always takes place in the direction of our efforts, what are the best methods of organization and administrative techniques for effecting this balance? (It is interesting to note, for example, that in Russia the Commisariat of Health is responsible not only for the ordinary preventive and therapeutic services, but also for such things as medical education and the control of prostitution. It is also interesting to note that the Commisar himself is not a physician.) Can co-ordination of the various health services be achieved without undue sacrifice of democratic ideals and democratic practices?

For the moment, at any event, there can be no final answers to these questions. At the very least, however, it may be admitted that the Soviet experiments and experience will repay careful scrutiny. If for no other reason, Sigerist's book, in spite of occasional bursts of uncritical enthusiasm, represents a substantial contribution to our knowledge and understanding of what is occurring elsewhere in the world.

Douglass V. Brown, M.D.

EDITORIAL

Most physicians, particularly young physicians, are constantly asking themselves questions regarding how they can improve the handling of their patients. They are earnestly urged to read carefully "Frightened People" by Professor Elton Mayo, professor of Industrial Research at the Harvard Graduate School of Business Administration. The young physician of Queensland described by Professor Mayo, assumed that his patients had an interest in science equal to his own and zealously attempted to educate them. He found that his practice was much more successful when he abandoned this method. The moral of this is perhaps something as follows: first, we should diagnose, treat and prevent; second, allay fear; third educate. An extreme example occurs to our mind. A worthy, able, but somewhat absent-minded physician was once about to examine a young housewife. The patient was disrobed; the doctor's stethescope was in hand, but a question of the patient started him upon a long discourse on disease. The patient, finally getting tired and confused, politely asked, "Shall I get dressed, now?" "Why, of course," said the doctor who then put away his stethescope and forgot completely that he had failed to make an examination.

The diagnosis and treatment of the individual, as opposed to the case, has been the subject most discussed by the lecturers on the Care of the Patient. This is the art of medicine and it requires both time and patience. But, as Dr. Elton Mayo, intimates by directing their efforts better they can increase their aid to fellow human beings. We remember that in his spoken address Professor Mayo advised young physicians in a sense as follows: to avoid frightening patients and to be good listeners. The "conspiracy" of the situation between doctor and patient is often to educate while reducing fear.

DEPARTMENT OF LEGAL MEDICINE

The public service of the Harvard Medical School will, it is believed, be materially enlarged through the newly-formed Department of Legal Medicine. Professor Alan R. Moritz, after a year in Europe, will return to Boston to build up that department.

Dr. Moritz came to Harvard in 1937 from the University Hospitals, Cleveland, as the first holder of the Professorship of Legal Medicine established under the "George Burgess Magrath Endowment for Legal Medicine." Dr. Moritz succeeded to the late Dr. George B. Magrath, who taught Legal Medicine at Harvard from 1907 to 1937.

NOTICE

There will be a dinner for the Alumni of the Harvard Medical School during the meeting of the American Medical Association at St. Louis. The dinner will be held on May 17th at the University Club.

It is hoped that all Alumni at the meeting will attend. Further information will be published in the next issue of the *Bulletin*.

Harvard Medical School Fellowships

Twenty-four fellowships totalling $21,650. were awarded by the Harvard Medical School for the academic year, 1938-1939.

Fellowship	Awarded to	Department
Edward Austin Fund Teaching Fellowships	Oliver H. Lowry	Biochemistry
	Duncan E. Reid	Obstetrics
	Bernard R. Hodes	Physiology
	James M. Parker	Surgery
Edward Hickling Bradford Fellowship, for research	Francis Sargent Cheever	Bacteriology
John White Browne Scholarship, for research	Smith Owen Dexter, Jr.	Medicine
William Story Bullard Fellowships, for research	Arnold Max Seligman	Chemistry
	Bernard David Davis	Physical Chemistry
	Lawrence Kingsland, Jr.	Medicine
Arthur Tracy Cabot Fellowship, for advancement of surgery	John E. Dunphy	Surgery
James Jackson Cabot Fellowship, "to aid and encourage practical work in scientific medicine"	John Holmes Dingle	Surgery
DeLamar Student Research Fund	Bernard German	Bacteriology
	Nathaniel B. Kurnick	Physiology
	Stanley M. Levenson	S. P. H.
	Edward Meilman	Biochemistry
	John Holmes Dingle	Surgery
Louis E. Kirstein Fellowship	Louis H. Nason	Surgery
William O. Moseley Jr. Travelling Fellowship, for study in Europe	Dale Gilbert Friend	Biochemistry
	Rolf Lium	Surgery
	John Burton Dynes	Psychiatry
Francis Weld Peabody Memorial Fellowship, for intensive clinical and laboratory studies	Arnold P. Meiklejohn	Medicine
Jeffrey Richardson Fellowship, for continuation of studies either here or abroad	Lewis Dexter	Medicine
The Whitman Fund, for pursuing the study of Medicine or surgery at the Ecole de Medicine de Paris	John Burton Dynes	Psychiatry
Dr. William Hunter Workman Scholarship, to enable graduates of H. M. S. to pursue postgraduate studies in medicine in this country or abroad	Robert P. Tucker	Biochemistry

DR. STRONG RETIRES

Dr. Richard P. Strong, world-famous authority on infectious and tropical diseases, since 1913 Professor of Tropical Medicine at the Harvard Medical School, has retired from active teaching and has been named Professor Emeritus.

In his forty years of medical work, Dr. Strong has led medical expeditions to all parts of the world. One year after graduating from John Hopkins Medical School in 1897, he entered the U. S. Army medical service, serving until 1902. From 1899 to 1901 he was president of the Army board appointed to study tropical diseases in the Philippine Islands. He was Director of the Government Biological Laboratory, Manila, 1901-1913, and Professor of Tropical Medicine at the University of the Philippine Islands 1907-13.

Dr. Strong was appointed Professor of Tropical Medicine at Harvard in 1913 at the time of the establishment of the Harvard School of Tropical Medicine, the first of its kind in America. Recognizing the value of this work to their enterprises in the tropics, the United Fruit Company later appointed Dr. Strong director of all their medical undertakings.

During the World War he served with the British and French armies in the summer of 1917, and was later assigned to the A. E. F. headquarters, reaching the rank of Colonel. He was a member of the inter-Allied Sanitary Commission in charge of the Division of Infectious Diseases. One of his principle wartime services was combating the typhus epidemic in Serbia. His decorations included the Distinguished Service Medal, the British Companion of the Bath, French Officer of the Legion of Honor, Chinese Striped Tiger, and Serbian Grand Officer Cross of St. Sava.

A graduate of Yale in 1893, Dr. Strong took his M.D. at Johns Hopkins in 1897. He has received honorary degrees from Harvard and Yale.

APPOINTMENTS TO THE STAFF

For the current academic year:

Lucie Adelsberger, of Berlin, Germany, as Instructor in Bacteriology; M.D. Friedrich-Alexanders-University, Erlangen, 1923.

Georg Schlomer, of Berlin, Germany, as Instructor in Psychiatry; M.D. Munich 1910.

Charles R. Atwell, of Boston, Mass., as Instructor in Psychology; A.M. Harvard 1931.

George M. Wyatt, of Wilmore, Ky., as Instructor in Roentgenology; M.D. Western Reserve 1933.

Rupert A. Chittick, of Waverly, Mass., as Assistant in Psychiatry; M.D. Harvard 1929.

Thomas Colver, of Great Ormond Street Hospital, London, as Research Fellow in Medicine; M.R.C.P. London 1935.

Kenneth M. A. Perry, of London, as Research Fellow in Medicine; M.R.C.P. London 1937.

Rulon W. Rawson, of Chicago, Ill., as Research Fellow in Medicine and Assistant Physician to the Collis P. Huntington Memorial Hospital; M.D. Northwestern 1938.

William W. Sargent, of Boston, Mass., as Research Fellow in Psychiatry, D.P.M. England 1936.

To September, 1939:

Charles L. Fox, Jr., of Boston, Mass., as Research Fellow in Bacteriology, M.D. Long Island 1934.

Albert M. Moloney, of Boston, Mass., as Assistant in Roentgenology, M.D. Tufts 1925.

James S. Manfield, of Boston, Mass., as Assistant in Medicine, M.D. Harvard 1932.

Chia-Tung Teng, of Boston, Mass., as Research Fellow in Medicine, M.D. Peiping Union 1933.

From October 1, 1938 to July 1, 1939:

Francis R. Dieuaide, of Peiping Union Medical College, Peiping, China, as Research Associate in Biological Chemistry; M.D. Johns Hopkins 1920.

From November 1, 1938, to September 1, 1939:

Thomas R. C. Fraser, as Research Fellow in Medicine, D.P.M. London 1937.

Alfredo Lanari, of Beunos Aires, as Research Fellow in Physiology; M.D. Beunos Aires 1934.

Eric K. Cruickshank, of Aberdeen, Scotland as Research Fellow in Surgery; M.B., CH.B. Aberdeen University 1937.

Maximilian G. Verlot, of Ghent, Belgium, as Research Fellow in Surgery; M.D. Ghent 1935.

From January 1, 1939 to September 1, 1939:

Adolph Meltzer, of New York, N. Y., as Assistant in Surgery; M.D. Cornell 1934.

Maurice H. Greenhill, as Research Fellow in Psychiatry; M.D. University of Chicago 1936.

NECROLOGY

'68-'69—WILLIAM EMERSON TUCKER died at Ipswich, Mass., December 3, 1938.

'69-'70—DANIEL MOSES FISK died at Topeka, Kan., September 30, 1932.

'81—FREDERICK WILLIAM JOHNSON died at Newton Centre, Mass., December 3, 1938.

'83—RUFUS PEABODY HUBBARD died at New York City, January 7, 1939.

'83—JOSEPH BRIGGS MURPHY died at Taunton, Mass., September 5, 1937.

'84-'85—EDWIN EMERY HALE died at North Attleboro, Mass., July 30, 1936.

'85—GUSTAVUS CROCKER SIMMONS died at Inverness, Calif., August 8, 1938.

'87—HEMAN LINCOLN CHASE died at East Alstead, N. H., November 17, 1938.

'87—EDWARD HOWARD died at San Diego, Calif., March 19, 1937.

'87-89—BRADLEE ROGERS died at Boston, Mass., December 28, 1938.

'87-'90—THEODORE PARKER WOLF died at Los Angeles, Calif., October 8, 1938.

'88—PERCIVAL JAMES EATON died at Orlean, N. Y., December 28, 1938.

'94—ALFRED AUGUSTUS WHEELER died at Leominster, Mass., July 22, 1938.

'95-98—JOHN FRANKLIN HARVEY died at Boston, Mass., January 16, 1937.

'96—BERTELL LAROY TALBOT died at Milford, N. H., July 14, 1938.

'97—FRANK ELIOT STETSON died at New Bedford, Mass., October 20, 1938.

'98—RUSH OLIVER LEES died at Utica, N. Y., October 3, 1938.

'02—FRANCIS JOSEPH JONES died at Providence, R. I., December 17, 1936.

'03—JAMES WALTER MYER died at Pelham, N. Y., June 11, 1938.

'07—DONALD GREGG died at Boston, Mass., January 6, 1939.

'09—JOHN JOSEPH HEALEY died at Providence, R. I., May 4, 1936.

'09—ARTHUR LIONEL PATCH died at Windsor, Vt., September 17, 1938.

'12—EDWARD LEVIS PRIZER died at Southern Pines, N. C., September 7, 1938.

'13—CHARLES SERPA NEVES died at Montclair, N. J., November 4, 1938.

'17—DENNIS RIDER WOOD CRILE died at Altadena, Calif., March 21, 1938.

'18—ROBERT ADDISON MILLIKEN died at Little Rock, Ark., November 1, 1938.

'21—FRANCIS XAVIER SHEA died at Everett, Mass., February 10, 1937.

'22—ADOLPH BERNHARD QUASSER died at Jacksonville, Fla., February 3, 1938.

ALUMNI NOTES

'87—Homer Gage who died July 4, provided in his will for a bequest of $100,000 to the American Antiquarian Society, Worcester, Mass.

'98—Hugh Cabot was married October 8 to Mrs. Elizabeth Cole Amory.

'95—Elliott P. Joslin, clinical professor of medicine, *Emeritus*, at the Harvard Medical School delivered two Malthe lectures and conducted a clinic in Oslo, Norway and took part in a symposium on protamine insulin, held in Stuttgart, Germany during September.

'96—Harris P. Mosher, who served as president of the American Otological Society for the year 1937-38, has been elected an honorary member of the American Academy of Ophthalmology and Otolaryngology.

'98—Lincoln Davis has been elected a trustee of the Massachusetts General Hospital to succeed the late Nathaniel T. Kidder. Davis has been a member of the staff of the hospital since 1903; from 1929 to 1932 he was chief of the East Surgical Service and since the latter year has been a member of the consultation board.

'99—Robert B. Osgood, John B. and Buckminster Brown professor of orthopaedic surgery, *Emeritus*, at the Harvard Medical School, is secretary of the medical advisory board of the Nemours Foundation for Crippled Children.

'03—Fred H. Albee of New York City is vice-president of the Academy of Physical Medicine.

'03—Winsor M. Tyler has moved to 1482 Commonwealth Ave., Boston.

'05—Hilbert F. Day has been reëlected president of the Cambridge Tuberculosis and Health Association.

'05—George C. Shattuck has been promoted from assistant professor to clinical professor of Tropical Medicine in the Harvard Medical School and the Harvard School of Public Health.

'06—J. Archer O'Reilly has been promoted from associate professor to professor of orthopaedic surgery at the St. Louis University School of Medicine.

'07—Cornelius E. Geary of Fitchburg has been reappointed medical examiner of the third Worcester district of Massachusetts.

'12—Philip D. Wilson, clinical professor of orthopaedic surgery at the College of Physicians and Surgeons, Columbia University, is a member of the medical advisory board of the Nemours Foundation for Crippled Children. The foundation, which was established under the will of the late Alfred I. du Pont, is erecting near